Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	011840	A. BUILDING: _____ B. WING _____	R 04/13/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE WEST	55 N MISSION DR INDIANAPOLIS, IN 46214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on February 16, 2016. Survey dates: April 13, 2016 Facility number: 011840 Provider number: 011840 AIM number: N/A Residential Census: 54 Sample: 10 Summit Place West was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey. Quality review completed April 15, 2016 by 29479.	{R 000}		